Washington State Health Care Authority
Public Employees Benefits Board

Public Employees Benefits Board (PEBB)

2009 COBRA Continuation or Extension of Coverage

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- **We must receive your first payment before you can be enrolled.** (Make checks payable to the Washington State Treasurer.)
- List only eligible family members you wish to cover.
- Attach appropriate dependent certification forms if required (spouse or qualified domestic partner, students age 20 through age 23, extended dependents, and dependents with disabilities.)
- If you have a child age 20-24 who is not a student, he or she may qualify for PEBB adult dependent coverage. (See the *Adult Dependent Enrollment/ Change* form.)

Forms are available at www.pebb.hca.wa.gov or by calling 1-800-200-1004.

Employee/Retiree Information ONLY	Employee/retiree name	
	Employee/retiree social security number	Date employer coverage ended (mm/dd/yyyy)
Are you making chages to an existing account? ❑ Yes ❑ No		

Section 1: SUBSCRIBER INFORMATION

Social security number	Sex ❑ M ❑ F	Last name	First name	Middle initial
Address				Apt./unit number
City	State	ZIP Code	County of residence	
Date of birth (mm/dd/yyyy)	Work phone number (including area code) ( )		Home phone number (including area code) ( )	

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only ❑ Dental only

❑ **Cancel all coverage** **Reason**_____ **Date of event** _____

Are you covered by another group medical or dental plan? ❑ Yes ❑ No Effective date_____

Are you disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No Effective date_____

Are you disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No Effective date_____

If yes, you must send a copy of your Social Security Disability Award letter.

Are you enrolled in Part(s) A and/or B of Medicare?
Part A (hospital) ❑ Yes ❑ No Effective date_____
Part B (medical) ❑ Yes ❑ No Effective date_____

Note: If you are enrolled in Medicare Part(s) A and/or B, you must send a copy of your Medicare card(s) along with this form.

Section 2: SPOUSE OR QUALIFIED DOMESTIC PARTNER INFORMATION

Relationship to subscriber: If adding a spouse, please attach a completed *Spouse or Qualified Domestic Partner Certification* form.
If adding a qualified domestic partner, please attach either a completed *Spouse or Qualified Domestic Partner Certification* form, or a copy of your *Certificate of State Registered Domestic Partnership* or registration card and a *Declaration of Tax Status* form.

❑ **Spouse:** date of marriage_____ ❑ **Qualified domestic partner:** date established/registered _____

Social security number	Last name	First name	Middle initial	Sex ❑ M ❑ F	Date of birth (mm/dd/yyyy)
Address (if different from subscriber)	City		State	ZIP Code	

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only ❑ Dental only

❑ **Cancel all coverage** **Reason**_____ **Date of event** _____

Are you covered by another group medical or dental plan? ❑ Yes ❑ No Effective date_____

Are you disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No Effective date_____

Are you disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No Effective date_____

If yes, you must send a copy of your Social Security Disability Award letter.

Are you enrolled in Part(s) A and/or B of Medicare?
Part A (hospital) ❑ Yes ❑ No Effective date_____
Part B (medical) ❑ Yes ❑ No Effective date_____

Note: If you are enrolled in Medicare Part(s) A and/or B, you must send a copy of your Medicare card(s) along with this form.

Section 3: FAMILY MEMBER INFORMATION *Use additional forms for more members. List only eligible family members.*

A	Relationship to subscriber	Social security number	❑ Disabled? ❑ Student? *Check only if age 20 or older.*	Sex ❑ M ❑ F

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Address (if different from subscriber)	City	State	ZIP Code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only ❑ Dental only

❑ **Cancel all coverage** **Reason**_____ **Date of event** _____

Are you covered by another group medical or dental plan? ❑ Yes ❑ No Effective date_____

Are you disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No Effective date_____

Are you disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No Effective date_____

If yes, you must send a copy of your Social Security Disability Award letter.

Are you enrolled in Part(s) A and/or B of Medicare?

Part A (hospital) ❑ Yes ❑ No Effective date_____

Part B (medical) ❑ Yes ❑ No Effective date_____

Note: If you are enrolled in Medicare Part(s) A and/or B, you must send a copy of your Medicare card(s) along with this form.

Section 4: CHANGES *Check all that apply. You must submit this form and any dependent forms within **60 days** of the event.*

- ❑ Name
- ❑ Address
- ❑ Medical plan
- ❑ Dental plan
- ❑ Adding a spouse or qualified domestic partner due to marriage or qualified domestic partnership (see Section 2)
- ❑ Adding newly acquired child(ren) due to birth, adoption, guardianship, marriage, or qualified domestic partnership
- ❑ Adding a dependent due to court order or medical support order (attach copy of court order or medical support order)
- ❑ Loss of other comprehensive group coverage
- ❑ Change in employment status
- ❑ Terminating a dependent's coverage due to divorce, legal separation, or termination of qualified domestic partnership
  Provide former spouse's or partner's new address
  _____
  _____
- ❑ Terminating a dependent's coverage due to death
- ❑ Terminating a dependent's coverage due to loss of eligibility for PEBB coverage
- ❑ Other (explain) _____

Date of event _____

Section 5: MEDICAL PLAN SELECTION

Check only one. Contact plans for more information; their contact information is at the end of this form.

- ❑ Aetna Public Employees Plan of Washington

Group Health Cooperative
- ❑ Group Health Classic
- ❑ Group Health Value

Kaiser Foundation Health Plan of the Northwest
- ❑ Kaiser Permanente Classic
- ❑ Kaiser Permanente Value

- ❑ Medicare Supplement Plan E, administered by Premera Blue Cross
- ❑ Medicare Supplement Plan J, administered by Premera Blue Cross

PacifiCare of Washington, Inc.
- ❑ Secure Horizons Classic (Medicare enrollees only)
- ❑ Secure Horizons Value (Medicare enrollees only)

- ❑ Uniform Medical Plan

Section 6: DENTAL PLAN SELECTION

Check only one. Contact plans for more information; their contact information is at the end of this form.

Preferred Provider Organization

- ❑ Uniform Dental Plan (Group #3000)
  (may receive services from *any provider*)

Managed Care Plans

- ❑ DeltaCare, administered by Washington Dental Service (Group #3100)
  Dentist name_____
  (must receive services from *DeltaCare provider*)
- ❑ Willamette Dental of Washington, Inc.
  Clinic location _____
  (must receive services from *Willamette Dental Group provider*)

Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

Section 7: SIGNATURE *Required*

I have received and read the *Continuation of Coverage Election Notice* including any appendices. By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB rules, I must repay any claims paid by my health plan(s). My family members and I may also lose PEBB benefits as of the last day of the month we qualified. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB benefits.

If I send payment, this does not mean that I will be automatically enrolled in PEBB insurance coverage. The PEBB Program will verify eligibility for me and my family members. If we do not qualify, I will receive a refund.

This form replaces all previous *COBRA Continuation or Extension of Coverage* forms I have submitted for PEBB benefits.

HCA's Privacy Notice:
We will keep your information private as allowed by law. To see our Privacy Notice, call 360-923-2822 or go to **www.hca.wa.gov.**

Subscriber's signature _____ Date_____

Please sign and date this form.

Return to:
Washington State Health Care Authority,
P.O. Box 42684, Olympia, WA 98504-2684

If payment enclosed, return to:
Washington State Health Care Authority,
P.O. Box 42695, Olympia, WA 98504-2695

2009 PEBB MEDICAL CONTRACTORS

Aetna Public Employees Plan of Washington, P.O. Box 14089, Lexington, KY 40512-4089
1-800-222-9205 or TTY 1-800-628-3323

Group Health Cooperative, 320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
1-800-813-2000 or TTY 1-800-735-2900

PacifiCare of Washington, Inc., 7525 SE 24th Street, Suite 200, P.O. Box 9005, Mercer Island, WA 98040-9005
1-800-647-7328 or TTY 1-800-387-1074

Premera Blue Cross, P.O. Box 327, Seattle, WA 98111-0327
1-800-817-3049 or TTY 1-800-842-5357

Uniform Medical Plan, P.O. Box 34850, Seattle, WA 98124-1850
1-800-762-6004 or TTY 1-888-923-5622

2009 PEBB DENTAL CONTRACTORS

DeltaCare, administered by Washington Dental Service, 9706 Fourth Avenue NE, Seattle, WA 98115-2157
1-800-650-1583

Uniform Dental Plan, 9706 Fourth Avenue NE, Seattle, WA 98115-2157
1-800-537-3406

Willamette Dental of Washington, Inc., 6950 NE Campus Way, Hillsboro, OR 97124-5611
1-800-360-1909